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3. Effective with service dates on or after March 1, 1992, the following will occur:

   a. The nursing facilities are to record, for verification by the contract auditor, the costs incurred with oxygen concentrators purchased by the facility.

   b. Allowable costs of oxygen concentrators shall be defined as follows: All concentrators purchased by nursing facilities shall be capitalized over the useful life of the asset. All supplies and service costs are allowable.

   c. The costs of the oxygen concentrators shall be included in the next rates set by the cost reporting period.

B. Oxygen concentrators provided by medical supply companies to Medicaid nursing home residents.

   1. These costs shall not be included in the Financial and Statistical Report (MED-13 Cost Report).

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II. Classification - For purposes of reimbursement under Medicaid, there are five classes of nursing facilities:

Class I - Includes nursing care facilities and beds treating the general nursing facility population.

Class II - Includes ICF/MR facilities treating minimum to moderately and specialized intensive developmentally disabled individuals.

Class IV - Includes ICF/MR facilities treating specialized intensive and intensive medical/psychosocial developmentally disabled individuals.

For purposes of this classification there are two types of Class IV facilities which are reimbursed under two different reimbursement methodologies. The State administered facilities are reimbursed in accordance with the methodology specified in Section III of the Methods section of this Attachment.

The private, non-profit or proprietary Class IV facilities are reimbursed in accordance with the same methodology as for the Class I, II and V facilities. The maximum rate calculations for these non-State administered facilities shall include the costs statistics and patient days of all Class IV facilities. These Class IV facilities will receive a fluctuating cost allowance, fair rental allowance and may earn an incentive allowance.

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Class V - Includes and is limited to the one rehabilitation facility treating the rehabilitation needs of the adult population predicated upon reasonable assurance of progress toward developmental improvement or at the very least, the maintenance of an acceptable condition which would deteriorate without placement.

III. Non-allowable Costs - The following list includes items and services which are not allowable for Medicaid reimbursement:

ITEM	ICFs/MR
Clothing	Non-allowable
Cigarettes, cigars, pipes and tobacco	Non-allowable
Cosmetics (perfume, lipstick, etc.)	Non-allowable
Dry cleaning	Non-allowable
Eye/Hearing examinations	allowable
Eyeglasses and repairs	allowable
Hearing aides and batteries	allowable
Private duty nurses or aides	Non-allowable
Private room	Non-allowable

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ITEM	NF
Personal clothing	Non-allowable
Cigarettes, cigars, pipes and tobacco	Non-allowable
Cosmetics & grooming items and services in excess of those for which Medicaid payment is made	Non-allowable
Dry cleaning	Non-allowable
Eye/Hearing examinations (unless medically necessary and prescribed by a physician.)	Non-allowable
Eyeglasses and repairs	Non-allowable
Hearing aides and batteries	Non-allowable
Privately hired nurses or aides	Non-allowable
Private room except where therapeutically necessary	Non-allowable

IV. Recoveries - In the event that an audit or other competent evidence reveals that a provider is indebted to the Medicaid program, the State shall recover this amount either through a repayment agreement, by offsetting against current and future claims of the provider, through litigation, or by any other appropriate legal resource. Recovered amounts shall be reported to the Federal government through the HCFA 64.

IV. Appeals and hearing - The State has established procedures for appeals of nursing home rate determinations which allows providers to submit additional evidence and request prompt administrative review.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING FACILITY CARE

VII. Private pay rates - Under no circumstances shall the Medicaid per diem rate exceed the private pay rate of a facility. Calculation of this standard requires the following steps to be taken to assure an accurate and fair comparison of the Medicaid per diem rate to the private pay rate occurs:

A. For the same periods for which a Medicaid rate is in effect (without change), all the private pay rates of the facility are added together and the sum divided by the number of private pay patients of the facility (i.e.. weighted average).

B. The weighted average rate calculated in Step A is compared to the Medicaid rate in effect for the same period of time.

C. Should the weighted average private pay rate be lower than the Medicaid rate, the Medicaid rate is reduced to the weighted average private rate amount. Any past Medicaid rates which were inadvertently paid to the provider which were higher than the weighted average private pay rate shall cause a recovery of the excessive Medicaid payments.

D. In cases where the provider received late notice of the rate changes effective July 1, 1987, (due to the change in rate setting methodology), this standard shall not be applied.

E. In cases where the OBRA'87 pass through or rate add-on payment causes the providers' Medicaid rate to exceed the private pay rate, the rate shall not be reduced as required by this section.

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Public Process for Rate-Setting: Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

ATTACHMENT A

OBRA'87 Topic: Requirements Relating to Provision of Services

Summary Impact on: Nursing Facility

OBRA'87 Requirement	State Requirement	Fiscal Impact
Quality of Life		
• Promote the maintenance/ enhancement of patient quality of life.	Previous State regulations did require social work and activity programming to meet needs of residents. State regulations also required same qualification at these regulations.	The interpretative guidelines seem to indicate a higher level of effort that required in the past. The State assumes NFs will need to increase their social work and/or activity staff personnel by approximately 25 percent of an FTE. Average costs per activity/social worker personnel is assumed to be $10.48 per hour. Assuming a full time person works 2,080 hours, a quarter person is 520 hours. There are 183 NFs = $997,276 x 65 percent Medicaid patients x 75 percent of the year (10/1/90 - 6/30/91) = $486,172. The State has a special program of providing mental health services to nursing facility residents which is not reimbursed through the nursing home rate structure and not a part of Section 4.19D. Further information on this special program is in Attachment D.

Transmittal No. 95-007
Date Approved 8/2/96
Effective Date 10/1/95
Supersedes Transmittal 90-010

ATTACHMENT A

OBRA'87 Topic: **Requirements Relating to Provision of Services**

Summary Impact on: **Nursing Facility**

OBRA'87 Requirement	State Requirement	Fiscal Impact
Quality of Life		
NF must:		
• Maintain quality assessment and assurance committee - composed of nursing director, physician, and three other staff members; committee must meet quarterly to identify quality assurance activities and implement plans to correct deficiencies.	Previous State requirement.	Since NFs required to meet this requirement no increase due to OBRA'87.

Sec. 1919(b) (1)

Transmittal No. 95-007
Date Approved 8/2/96
Effective Date 10/1/95
Supersedes Transmittal 90-010

ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Provision of Services

Primary Impact on: Nursing Facility

OBRA '87 Requirement	State Requirement	Fiscal Impact
Plan of Care Services must be provided according to a plan of care. Plan to be developed by: • attending physician • RN • Resident or representative Plan must describe patients medical, nursing and psychosocial needs, and how needs will be met. Plan must be reviewed/revised periodically following resident assessment. [Sec. 1919(b)(2)]	Previous State requirement.	No new cost increase due to OBRA '87. The State has previously required comprehensive plans of care, developed by the attending physician, RN, resident or representative. OBRA '87 does introduce the new MDS form which will be the principle plan of care document. Pre-existing level of effort and cost experience will be used to meet the preparation requirements of the MDS. The State also estimates additional nursing time will be needed in the preparation than previously experience. This new level of effort is provided for in the fiscal impact found on page 3.

Plan ID: 95-007
Date Approved: 8/2/96
Effective Date: 10/1/95
Supersedes Transmittal: 90-010

ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Provision of Services

Primary Impact on: Nursing Facility

OBRA '87 Requirement	State Requirement	Fiscal Impact
Resident assessment must be conducted by RN no later than 4 days following admission.	Not previous State requirement, however, a general assessment of resident's conditions were required.	The resident assessment requirements of OBRA 87 are more extensive than State requirements. Please see Detailed Analysis, Attachment B.
Assessment must:		
• describe resident capabilities and significant impairments in performing ADLs	Same	The PASARR assessments were conducted by agencies independent of the NFs, therefore, NFs incurred no, or very little, cost for this review.
• be based on uniform minimum data set prescribed by HHS	Same	
• identify medical problems of Medicare-eligible residents	Same	
• use State-specified instrument for Medicaid-eligible residents	Previous State requirement	
• be performed at least once every 12 months, or after significant change in condition	Not previous State requirement, however, a general assessment of resident's conditions were required.	
• be coordinated with PAS to avoid duplication	Not previous State requirement.	
Preadmission screening (PAS) - MR/MI residents must not be admitted to NF without State MR/MI authority concurrence.		
[Sec. 1919(b)(3)]		